No. 16-1454

In the Supreme Court of the United States

STATE OF OHIO, ET AL.,
Petitioners,

v.

AMERICAN EXPRESS COMPANY, ET AL.,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Second Circuit

BRIEF OF *AMICI CURIAE* THE AMERICAN MEDICAL ASSOCIATION AND OHIO STATE MEDICAL ASSOCIATION IN SUPPORT OF PETITIONERS

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INTERESTS OF *AMICI*[1]

The American Medical Association (AMA) is the largest professional association of physicians, residents, and medical students in the United States. Additionally, through state and specialty medical societies and other physician groups seated in its House of Delegates, substantially all U.S. physicians, residents, and medical students are represented in the AMA's policymaking process. AMA members practice and reside in all states and in the District of Columbia. The objectives of the AMA are to promote the science and art of medicine and the betterment of public health.

The Ohio State Medical Association (OSMA) was founded in 1846, initially as the Ohio State Medical Society, to "foster legislation and activities which would safeguard the interests of the public . . . and elevate the standards of the medical profession." The OSMA's purpose remains undiluted over 170 years later, and is advanced by courageous and conscientious Ohio physicians who are devoted to providing the best practicable and affordable medical care possible.

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[1] No party's counsel authored this brief in whole or in part. No party or its counsel contributed money to fund preparing or submitting this brief. No person—other than the AMA and the OSMA, their members, or their counsel—contributed money to fund preparing or submitting this brief. Consents from all relevant parties to the filing of briefs by *amici curiae* have been granted.

The AMA and OSMA join this brief on their own behalves and as representatives of the Litigation Center of the American Medical Association and the State Medical Societies. The Litigation Center is a coalition among the AMA and the medical societies of each state, plus the District of Columbia, whose purpose is to represent the viewpoint of organized medicine in the courts.

The *amici* and their members have an interest in ensuring that physicians can deliver high-quality, affordable care to their patients. The *amici* are concerned that dominant healthcare entities may adopt anticompetitive, anti-referral rules that are antithetical to the delivery of high-quality and, indeed, necessary medical care in the United States. The *amici* and their members contend that the Second Circuit decision's departure from well-established antitrust precepts that concern "two sided" platforms, if not reversed by this Court, will make it more likely that anti-referral rules that are imposed upon physicians by dominant entities and which, in turn, harm the quality of healthcare delivery, will be immunized from antitrust scrutiny. Moreover, the *amici* and their members contend that the deterrent effect of antitrust law to prohibit these anticompetitive practices will be severely compromised if the Second Circuit decision is not reversed.

To assure that anticompetitive restraints do not improperly restrict physician medical judgment and, thus, the quality of healthcare services, the Court should reverse.

SUMMARY OF ARGUMENT

The district court found, after a full, seven week bench trial, that anti-steering provisions that American Express imposed in its contracts with merchants, and which precluded merchants from requesting payments cards other than American Express when American Express cards were presented, violated the Sherman Act § 1, 15 U.S.C. § 1. *United States v. Am. Express Co.*, 838 F.3d 179, 184 (2d Cir. 2016) (citing 88 F. Supp. 3d 143 (E.D.N.Y. 2015)). The Second Circuit did not disturb the district court's factual findings that those provisions eliminated horizontal inter-brand competition for merchants, raising prices and stifling innovations in payment-card network services. Nonetheless, the Second Circuit reversed the district court and ordered judgment in favor of American Express.

The Second Circuit grounded its holding in the notion that electronic-payments networks compete through supplying "two-sided" platforms—*i.e.*, platforms that have a merchant "side" and a cardholder "side." The Second Circuit held that, when confronted with the question of whether a two-sided platform has engaged in anticompetitive conduct, a court must evaluate market power and anticompetitive impact by defining a relevant market that encompasses both sides of the platform. *See Am. Express*, 838 F.3d at 196, 200 (holding that the district court's market definition was "fatal to its conclusion" because the district court "expressly declined 'to define the relevant product market to encompass the entire multi-sided platform.'") Specifically, the Second Circuit held that, in order to for a plaintiff to make a *prima facie* case of

anticompetitive impact under the Rule of Reason in a case concerning network platforms, a plaintiff must show that the alleged restraint caused harm on a "net" basis across both sets of platform users. *Id.* at 183 (holding that "[w]ithout evidence of the [anti-steering rules'] net effect on both merchants and cardholders," there could be no restraint of trade). For the reasons discussed by Petitioners and other *amici curiae* in support of Petitioners, the Second Circuit's holding is contrary to well-established law, including decisions of this Court, and would, in many cases, create administrative burdens upon litigants and courts that would be nearly impossible to meet. *See e.g.*, Brief for the Petitioners and Respondents Nebraska, Tennessee, and Texas and Brief for the United States as Respondent Supporting Petitioners.

The AMA and the OSMA submit this brief to demonstrate how the ability of the antitrust laws to discipline anticompetitive behavior in healthcare markets, and to help spur best medical outcomes, could be significantly and negatively compromised if the Second Circuit decision survives. For example, dominant healthcare "platforms," such as health-insurer networks, compete on "two sides," inasmuch as they supply services to (i) a market for medical services provided to patients that are purchased by health insurance plans on one side of the platform and (ii) an inter-related, but distinct, market of commercial health insurance policy sales to subscribers on the other side of the platform.[2]

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[2] Studies have found that health insurance markets are highly concentrated in many geographic areas within the United States. *See e.g.*, AMA, *Competition in Health Insurance: A Comprehensive*

Such dominant health insurance networks (or their agent benefit managers) have imposed and could further impose rules or effectively erect barriers that prohibit physicians from referring patients to certain specialists, particularly out-of-network specialists, for innovative and even necessary medical tests. Notwithstanding such restraints' material interference with physician judgment and harm to patient care, under the Second Circuit's ruling below, governmental, patient, or physician plaintiffs could not make a *prima facie* case that the restraint was anticompetitive unless they were able to demonstrate that the restraint caused a "net" harm to both the medical services and commercial insurance markets. Under the Second Circuit's decision, an antitrust plaintiff challenging those restraints would face the exceedingly difficult, if not impossible, burden of quantifying both the harm to patient care and harm to commercial insurance subscribers—and then netting out the latter from the former.

Under a century of precedent applying the Rule of Reason—the most searching mode of analysis applied under antitrust law—the plaintiff bears the initial burden to show that a challenged practice adversely affects competition and consumers in a relevant

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Study of U.S. Markets, 2017 Update. This study from the American Medical Association indicates that "[s]ixty-nine percent of MSA-level health insurance markets in the U.S. are highly concentrated, based on guidelines used by the Department of Justice and Federal Trade Commission). *See also* American Hospital Association, *Study: Most health insurance markets are highly concentrated* (Sept. 8, 2015), http://news.aha.org/article/150908-study-most-health-insurance-markets-highly-concentrated.

market; and the practice's effects in another relevant market on some other distinct set of entities are irrelevant to this initial inquiry. This well-settled approach provides an administratively feasible way for physicians and patients to challenge restraints that are likely to materially interfere with the physician's judgment and potentially cause patient harm. The AMA and the OSMA submit that antitrust law's ability to discipline anticompetitive practices that harm patient care will be significantly eroded if the Second Circuit's "net harm" approach becomes the standard that plaintiffs must satisfy to make a *prima facie* Rule of Reason case against network platforms. This Court should reverse.

BACKGROUND

The duty of physicians to provide best medical care to their patients is paramount. AMA, Preamble, AMA Principles of Medical Ethics, https://www.ama-assn.org/delivering-care/ama-principles-medical-ethics (last visited Dec. 7, 2017) ("As a member of this profession, a physician must recognize responsibility to patients first and foremost, as well as to society, to other health professionals, and to self."). Physicians are, indeed, ethically obligated to provide the best practicable medical care to their patients. AMA Code of Medical Ethics Opinion 1.1.6, https://www.ama-assn.org/delivering-care/quality (last visited Dec. 7, 2017) ("Individually and collectively, physicians should actively engage in efforts to improve the quality of health care by: (a) Keeping current with best care practices and maintaining professional competence...").

> The practice of medicine, and its embodiment in the clinical encounter between a patient and a

> physician, is fundamentally a moral activity that arises from the imperative to care for patients and to alleviate suffering. The relationship between a patient and a physician is based on trust, which gives rise to physicians' ethical responsibility to place patients' welfare above the physician's own self-interest or obligations to others, to use sound medical judgment on patients' behalf, and to advocate for their patients' welfare.

AMA, Code of Medical Ethics Opinion 1.1.1, https://www.ama-assn.org/delivering-care/patient-physician-relationships (last visited Dec. 7, 2017). Accordingly, physicians must make sure that restrictions are not placed upon them that materially compromise their primary duty: to ensure that the patient is provided with quality medical care.

Physicians often contract with health insurers that operate two-sided platforms. Physicians contract with health insurers to supply medical services to the health-insurer members as part of healthcare provider networks that health insurers assemble. Health-insurance plans, in turn, contract with physicians and other healthcare providers to form provider networks that will assure that the health insurers' members can access necessary and quality medical services at certain negotiated rates. *See e.g.*, 1996 Department of Justice and Federal Trade Commission Statements of Antitrust Enforcement Policy in Healthcare ("DOJ/FTC Health Care Statements") No. 8, at 81 (Aug. 1996) (physician joint ventures and groups "contract with [health] plans to provide physician services to plan subscribers at predetermined prices"),

https://www.ftc.gov/sites/default/files/attachments/competition-policy-guidance/statements_of_antitrust_enforcement_policy_in_health_care_august_1996.pdf.

Health insurers also provide network services to employers and individuals that purchase health insurance policies from them--policies that cover certain of the medical expenses that these employers or individuals would otherwise incur. *Saint Alphonsus Med. Ctr. - Nampa, Inc. v. Saint Luke's Health Sys.*, 778 F.3d 775, 784 (9th Cir. 2015) (quoting Gregory S. Vistnes, *Hospitals, Mergers and Two Stage Competition*, 67 Antitrust L.J. 671, 672 (2000)) (in case concerning the acquisition of a primary-care physician group, it is held that "the vast majority of health care consumers are not direct purchasers of health care—the consumers purchase health insurance and the insurance companies negotiate directly with the providers"). Health insurers compete to sell insurance products to employers and individuals: such competition is predicated on the premiums charged, benefits offered, and medical networks assembled by the health insurers. Physician contracts with insurance (or benefit-manager) networks sometimes preclude, either effectively or via contract, referrals to particular providers, particularly providers that are out-of-network and provide novel or innovative treatments. *See e.g.*, *Palmyra Park Hosp., Inc. v. Phoebe Putney Mem'l Hosp.*, 604 F.3d 1291, 1303 (11th Cir. 2010) (affirming denial of motion to dismiss and finding that providers excluded from insurer network suffered antitrust injury as exclusion led to fewer choices for patients). *See also New York v. Actavis PLC*, 787 F.3d 638, 659 (2d Cir. 2015) (indicating that anticompetitive

harm to healthcare consumers includes deterioration of "medically significant innovation").

These anti-referral provisions or barriers, if substantially restrictive and imposed by entities with substantial market power, may limit physician ability to make referrals that would otherwise be guided by the physician's best judgment and would lead to best medical outcomes. In this way, these restrictions could be wholly at odds with the physician's ethical responsibilities.[3] And because such restrictions could limit quality and choice, they raise competitive concerns that the antitrust laws traditionally have proscribed.

ARGUMENT

A. Healthcare services operate on networks or "platforms" with two sets of distinct users transacting in different markets.

As discussed, physicians and health care providers supply medical services that are purchased by health insurers for the benefit of their members. Providers compete on this side of the health insurer platform against one another by supplying superior services and competitive pricing to be included in the health insurer networks. They do not compete against insurers that supply policies to employers or individuals that seek to have their medical expenses covered. In this way, antitrust law has historically recognized that physicians participate in relevant markets for the

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[3] Hospitals may also adopt anti-referral rules that preclude physicians from referring cases in a manner that would be consistent with best medical judgment.

supply of medical services to health insurance plans that are separate and apart from markets for commercial insurance that are sold to employer and individual subscribers. For example, the section of the DOJ/FTC Health Care Statement No. 8 which concerns defining markets when applying the Rule of Reason, states that:

> if two hospitals formed a multiprovider network with their medical and other health care professional staffs, the Agencies would consider potential competitive effects in ***each*** market affected by the network, including, but not necessarily limited to, the markets for inpatient hospital services, outpatient services, each physician health care service provided by network members, and health insurance/ financing markets whose participants may deal with the network and its various types of health care providers.

Id. at 114-115 (emphasis supplied). *See also FTC v. Advocate Health Care Network*, 841 F.3d 460, 465 (7th Cir. 2016) (holding that markets exist for hospital services sold to health insurance plans); *accord St. Luke's Health Sys.*, 778 F.3d at 784.

On the subscriber side of the platform: the Antitrust Division recently and successfully preliminarily enjoined two health-insurer transactions —the acquisition of Humana by Aetna and the acquisition of Cigna by Anthem. In each case, the district court held that the relevant markets were those for the sale of commercial health insurance to employers and/or individuals, and analyzed the impact of the merger in the context of the relevant market for

the sale of commercial insurance to employers and/or individuals. The courts did not find that physicians or other health providers participated in these markets. *United States v. Anthem, Inc.*, 236 F. Supp. 3d 171, 179-80 (D.D.C. 2017) (finding that a relevant market for administrative, self-insured network products existed for "employers" who "have a unique set of characteristics and needs that drive their purchasing processes and decisions"), *aff'd*, *United States v. Anthem, Inc.*, 855 F.3d 345 (D.C. Cir. 2017); *United States v. Aetna Inc.*, 240 F. Supp. 3d 1, 8 (D.D.C 2017) (finding that the companies "compete head-to-head" in sale of health insurance to direct consumers).

The Second Circuit decision below conflates markets for the purchase of payment-card network services by merchants with markets for the use of payment-card network services by issuers and their cardholders. *Am. Express*, 838 F.3d. at 200 (reversing district court because it "expressly declined 'to define the relevant product market to encompass the entire multi-sided platform.'"). If that decision stands and is interpreted to apply to an analysis of healthcare platforms, it would be contrary to substantial precedent and would likely raise confusion concerning the appropriate scope of healthcare platform markets and how competition in them should be evaluated under the Rule of Reason. This should not occur.

B. The Second Circuit decision may wrongly require a plaintiff, in a healthcare platform case, to show net harm in order to establish a *prima facie case* under the Rule of Reason.

The district court below found, after a full bench trial, that American Express unreasonably restrained trade in violation of the Sherman Act § 1, 15 U.S.C. § 1, by forcing merchants to accede to anti-steering provisions that barred them from "(1) offering customers any discounts or nonmonetary incentives to use credit cards less costly for merchants to accept, (2) expressing preferences for any card, or (3) disclosing information about the costs of different cards to merchants who accept them." *Am. Express*, 838 F.3d at 184. Notwithstanding the undisputed fact that these anti-steering rules stifled horizontal competition, the Second Circuit reversed the district court. In so doing, the Second Circuit held "that without evidence of the [anti-steering rules'] net effect on both merchants and cardholders," there could be no restraint of trade. 838 F.3d at 183. The Second Circuit further held that the plaintiffs "bore the initial burden" to show net harm to competition on to two distinct set of customers, merchants and cardholders.

This Court has consistently rejected the Second Circuit's notion that the anticompetitive harm suffered by one distinct set of consumers in a relevant market can be offset by benefits to another distinct set of consumers in another market. *See, e.g.*, *United States v. Topco Assocs.*, 405 U.S. 596, 610 (1972) ("[T]he freedom guaranteed each and every business, no matter how small, is the freedom to compete . . . .

Implicit in such freedom is the notion that it cannot be foreclosed with respect to one sector of the economy because certain private citizens or groups believe that such foreclosure might promote greater competition in a more important sector of the economy"); *United States v. Philadelphia Nat'l Bank*, 374 U.S. 321, 370 (1963) ("If anticompetitive effects in one market could be justified by procompetitive consequences in another, the logical upshot would be that every firm in an industry could, without violating [the Clayton Act § 7], embark on a series of mergers that would make it in the end as large as an industry leader"). This Court has also evaluated platform industries, and found anticompetitive effects on one side of the platform without engaging in the "net harm" analysis mandated by the Second Circuit. *Times-Picayune Pub. Co. v. United States*, 345 U.S. 594 (1953). For this reason, the Second Circuit decision should be reversed.

In any event, as the Petitioning States and United States have argued, a Rule of Reason plaintiff, in order to make a *prima facie* case, must merely demonstrate that the challenged restrain caused an anticompetitive impact. *See e.g.,* Brief of the United States at 44-47. No precedent requires such a plaintiff in a healthcare platform matter to net out any procompetitive impacts that the challenged restraint may have caused—whether those benefits occurred inside or outside the market at issue—to sustain such a *prima facie* case. If anything, the burden of proving whether procompetitive benefits offset the restraint's anticompetitive effects falls upon the platform defendant *after* the plaintiff has carried its initial burden. *Id.* Affirmance of this decision would therefore be contrary to existing law and potentially

impose new and extremely difficult burdens on a plaintiff challenging health care platform restrictions under the Rule of Reason.

If this Court adopts the Second Circuit's framework, it may require a government, physician, or patient plaintiff to show competitive harm in healthcare by netting out harm to one group of consumers with potential benefits to another group. For example, dominant health insurers could impose anti-referral rules prohibiting physicians from referring patients to out-of-network specialists for innovative or medically-necessary tests that would enhance the patient's care. Such practices can constitute anticompetitive harm. *See e.g.*, *Medscan LLC v. New York Univ. School of Med.*, 430 F. Supp. 2d 140, 147 (S.D.N.Y. 2006) (plaintiff alleging that quality of diagnostic imaging services were reduced as a result of exclusionary conduct stated an antitrust claim). *See also New York v. Actavis PLC*, 787 F.3d 638, 659 (2d Cir. 2015) (indicating that anticompetitive harm to healthcare consumers includes deterioration of "medically significant innovation."); *Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program* § 1, 76 Fed. Reg. 67026 (Oct. 28, 2011) ("The Agencies recognize that . . . under certain conditions ACOs could reduce competition. . . through . . . lower quality of care.").[4] Under *American*

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[4] While this brief focuses on the actions of health insurers, the concerns that the AMA has regarding anti-referral rules equally apply to such rules when imposed by dominant hospital systems. Such systems, as a condition of offering privileges to the physician, could preclude that physician from referring business away from

Express, to make out a *prima facie* case challenging such anti-referral rules or practices under the Rule of Reason, an antitrust plaintiff may have to: (1) prove harm to patients who are prevented from seeing a particular specialist or undergoing a particular test; and then (2) balance that harm against the speculative benefits obtained by other participants in the network, particularly the benefit to other patients and insurance subscribers; and then (3) net out (2) from (1). The Second Circuit's rule could thus allow anti-referral rules that harmed patient care to withstand antitrust scrutiny because it would be exceedingly difficult for an antitrust plaintiff to meet this standard.

If this Court affirms, it would provide greater leeway for dominant entities to impose contractual restraints on a physician's ability to refer their patients for care which the physician deems best in their medical judgment. Physicians will have no choice but to accept those restraints, because rejecting them means turning away a large number of patients whom physicians would otherwise be able to serve—which is untenable from both a business and ethical standpoint. Physicians would then have to weigh, against what they deem best for their patients, the consequences of their breaching their contractual obligations. It would be difficult for them to find recourse under the antitrust laws in such situations.

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the hospital even when such referral would be in the interest of the patient. Such anti-referral policies would, in this sense, reduce the quality of medical services and thus are anticompetitive.

Material interference with physicians' medical judgments threatens physician autonomy, damages the doctor-patient relationship, decreases medical innovation, and lowers the overall quality of patient care. The antitrust laws have historically played an instrumental role in preventing such outcomes. This Court should ensure that antitrust law's vital role in health care continues by reversing the Second Circuit's decision.

CONCLUSION

Because the Second Circuit's decision below would undermine antitrust enforcement in healthcare, harm patient care, and enable interference with physicians' duty to their patients to provide the best medical care, this Court should reverse.

Respectfully submitted,

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